Division of Public and Behavioral Health

NAME OF PROVIDER OR SUPPLIER THE HAVEN 1206 PROVIDE OF LEAN AVE LAS VEGAS, NV 89123 VOID SUMMARY STATEMENT OF DESCRIPTION AVE LAS VEGAS, NV 89123 VOID PRETTX PRETTX PROVIDER OF SUPPLIED OF DESCRIPTION AVE LAS VEGAS, NV 89123 VOID Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a State Licensure survey and complaint investigation conducted on your facility from 6/25/13 through 6/27/13. This State Licensure survey and complaint investigation conducted on your facility from 6/25/13 through 6/27/13. This State Licensure survey and complaint investigation was conducted by the authority of NRS 449,0307, Powers of the Health Division. The facility is licensed for seven Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category 2 residents. The census at the time of the survey was five. Five resident files were reviewed and three employee files were reviewed and three temployee files were reviewed and three amployee files were reviewed and three deployees was initiated by the Nevada State Health Division on 6/25/13. Complaint #NV00036011: The complaint investigative process was initiated. See TAG Y 181. The allegation regarding insufficient access for wheelchairs was unsubstantiated. See TAG Y 181. The allegation regarding insufficient access for wheelchairs was unsubstantiated through biservation and services. The allegation regarding the facility being over census was unsubstantiated through to service from the survey was five.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
TH HEAVEN MAID PREPIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION PREPIX PREVIX DEFICIENCY MUST BE PRECEDED BY FULL PREPIX PREVIX DEFICIENCY MUST BE PRECEDED BY FULL PREPIX PREPIX PREVIX DEFICIENCY OF INSTANCE DEFINITION OF INSTANCE			NVS4961AGZ	B. WING		06/27/2013
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PREFIX TAG REQULATORY OR LSC IDENTIFYING INFORMATION) TAG Initial Comments Y 000 Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a State Licensure annual grading survey in conjunction with a complaint investigation conducted on your facility from 6/26/73 through 6/27/13. This State Licensure survey and complaint investigation was conducted by the authority of NRS 449.0307, Powers of the Health Division. The facility is licensed for seven Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category 2 residents. The census at the time of the survey was five. Five resident files were reviewed and three employee files were reviewed. The facility received a grade of D. Complaint #NV00036011: The complaint investigation regarding excessive heat was substantiated. See TAG Y 181. The allegation regarding insufficient access for wheelchairs was unsubstantiated through interview and observation. The allegation regarding the facility being over census	/ IN NEAV	/EN	LAS VEG	AS, NV 89123		
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		The findings and cond by the Health Division prohibiting any crimin actions or other claim available to any party state, or local laws. This Statement of Dea result of a State Lid survey in conjunction investigation conducted 6/25/13 through 6/27/survey and complaint conducted by the auth Powers of the Health The facility is licensed Facility for Group bed persons with Alzheim residents. The censul was five. Five resident three employee files was five. Five resident three employee files was State Health Division Complaint #NV00036 investigative process State Health Division Complaint #NV00036 regarding excessive had y 181. The alleg access for wheelchair through interview and regarding a resident be periods was substantiallegation regarding the	a shall not be construed as all or civil investigations, is for relief that may be under applicable federal, independent of the under applicable federal, in			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDIEAN	or doring of the state of the s	IDENTIFICATION NOWIDEN.	A. BUILDING: _	A. BUILDING:		
		NVS4961AGZ	B. WING		06/2	27/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
7TH HEAV	/EN		E DE LEON A' S, NV 89123	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
Y 000	Continued From page	e 1	Y 000			
	- Observations were in wheelchairs vs. the modern complaint #NV00036 regarding the facility in	ient access included: iducted with residents. made of the size of the naneuvering space available. 6011 - The allegation being over census included: iducted with caregivers who was five. The facility is sidents. aled only five residents were y. pectors revealed only five				
Y 106	The following deficier	ncies were identified: nnel File - 1st aid & CPR	Y 106			
SS=D	NAC 449.200 Staffing	g requirements; limitations tts; written schedule required				
	information required p	st include, in addition to the pursuant to subsection 1, g that the caregiver is perform first aid and				

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	,
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		NVS4961AGZ	B. WING		06/27/201	3
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
7TH HEAV	/FN	1205 PONC	E DE LEON A	VE		
7111111270		LAS VEGA	S, NV 89123			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CON	(X5) MPLETE DATE
Y 106	Continued From page	e 2	Y 106			
V 404	Based on record reviet the facility failed to enwere trained in first airesuscitation (CPR) (laid training completed first aid training comphands-on training). Severity: 2 Scope:		V.404			
Y 181 SS=I	449.209(8) Health an	d Sanitation-Temperature	Y 181			
	NAC 449.209 Health	and sanitation.				
	8. The temperature of the facility must be maintained at a level that is not less than 68 degrees Fahrenheit and not more than 82 degrees Fahrenheit. This Regulation is not met as evidenced by: Based on observation from 6/25/13 through 6/27/13, the facility failed to ensure the temperature in the facility was maintained at a level that was not less than 68 degrees Fahrenheit and not more than 82 degrees Fahrenheit for 5 of 5 residents. Severity: 3 Scope: 3 Findings include: On 6/25/13, the Nevada State Health Division was alerted to excessive temperatures in the facility. A complaint investigation was initiated resulting in an onsite visit. Upon arrival to the					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM 6899 V6VY11 If continuation sheet 3 of 10

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVO 4004 A O 7	B. WING		00/07/0040
		NVS4961AGZ			06/27/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	FE, ZIP CODE	
7TH HEAV	/EN		NCE DE LEON A	/E	
	I	LAS VEG	AS, NV 89123		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
Y 181	Continued From page	: 3	Y 181		
	Fahrenheit. Interview air-conditioning systel night and not turned of day. The residents als system was turned or onsite visit. Employee regulation to maintain 68-82 degrees. On 6/26/13, a return of conducted and observe temperatures. The fact degrees and an ambiguithermometer revealed (all temperatures Fahremained on site until 82 degrees. Employee the system checked for site of turning turning the system checked for site of turning tur	vations revealed excessive cility thermostat read 84 ent temperature d a reading of 86.8 degrees. renheit) Investigators the temperature dropped to ee #2 was advised to have or possible service needs aperature did not exceed			
Y 620 SS=D	449.2702(4)(a) Admis	ssion Policy	Y 620		
	NAC 449.2702 Writte eligibility for residency	n policy on admissions; /.			
	and 449.2754, a resid	e provided in NAC 449.275 lential facility shall not admit he facility any person who:			
	Based on observation	nt met as evidenced by: a, interview and record be facility failed to submit a			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM 6899 V6VY11 If continuation sheet 4 of 10

Division of Public and Behavioral Health

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	NVS4961AGZ	B. WING		06/2	7/2013
OVIDER OR SUPPLIER					
EN			VE		
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE DATE
Continued From page		Y 620			
waiver for one bedfas	t resident (Resident #5).				
Severity: 2 Scope:	1				
449.2722(3)(a)-(f) Bov	wel & Bladder Incontinence	Y 755			
condition of bowel or	bladder incontinence;				
facility with a resident condition of bowel or lensure that: (a) If the resident can toileting, he is assiste bathroom at regular ir (b) The resident is chewhen he is known to be during the night; (c) The resident is kep (d) Retraining program medical professional vin the care of persons dysfunction; (e) The retraining progresident are followed;	who has a manageable bladder incontinence shall benefit from scheduled dor reminded to go to the intervals. ecked during those periods be incontinent, including pt clean and dry; ms are designed by a with training and experience s with bowel or bladder grams established for a and				
=	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page waiver for one bedfas Severity: 2 Scope: 449.2722 Reside condition of bowel or lesidents having manior bladder. 3. The caregivers empleating with a resident condition of bowel or lesidents having manior bladder. 3. The caregivers empleating with a resident condition of bowel or lesidents having manior bladder. (a) If the resident can toileting, he is assisted bathroom at regular in (b) The resident is chewhen he is known to be during the night; (c) The resident is kept (d) Retraining programmedical professional wait in the care of persons dysfunction; (e) The retraining programmedical professional wait in the care of persons dysfunction; (f) Privacy is afforded	NVS4961AGZ DVIDER OR SUPPLIER STREET ADD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 waiver for one bedfast resident (Resident #5). Severity: 2 Scope: 1 449.2722 Residents having unmanageable condition of bowel or bladder incontinence; residents having manageable condition of bowel or bladder. 3. The caregivers employed by a residential facility with a resident who has a manageable condition of bowel or bladder incontinence shall ensure that: (a) If the resident can benefit from scheduled toileting, he is assisted or reminded to go to the bathroom at regular intervals. (b) The resident is checked during those periods when he is known to be incontinent, including during the night; (c) The resident is kept clean and dry; (d) Retraining programs are designed by a medical professional with training and experience in the care of persons with bowel or bladder designed to a resident are followed; and (f) Privacy is afforded to the resident when care is	NVS4961AGZ DVIDER OR SUPPLIER STREET ADDRESS, CITY, STA 1205 PONCE DE LEON A' LAS VEGAS, NV 89123 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 waiver for one bedfast resident (Resident #5). Severity: 2 Scope: 1 449.2722 Residents having unmanageable condition of bowel or bladder incontinence; residents having manageable condition of bowel or bladder incontinence shall ensure that: (a) If the resident can benefit from scheduled toileting, he is assisted or reminded to go to the bathroom at regular intervals. (b) The resident is checked during those periods when he is known to be incontinent, including during the night; (c) The resident is kept clean and dry; (d) Retraining programs are designed by a medical professional with training and experience in the care of persons with bowel or bladder dysfunction; (e) The retraining programs established for a resident are followed; and (f) Privacy is afforded to the resident when care is	DIVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1205 PONCE DE LEON AVE LAS VEGAS, NV 89123 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 waiver for one bedfast resident (Resident #5). Severity: 2 Scope: 1 449.2722(3)(a)-(f) Bowel & Bladder Incontinence NAC 449.2722 Residents having unmanageable condition of bowel or bladder incontinence; residents having manageable condition of bowel or bladder incontinence shall ensure that: (a) If the resident can benefit from scheduled toileting, he is assisted or reminded to go to the bathroom at regular intervals. (b) The resident is checked during those periods when he is known to be incontinent, including during the night; (c) The resident is checked during those periods when he is known to be incontinent, including during the night; (c) The resident is checked during those periods when he is known to be incontinent, including during the night; (c) The resident is checked during those periods when he is known to be incontinent, including during the night; (c) The resident is known to be incontinent, including during the night; (c) The resident is known to be incontinent, including during the night; (c) The resident is known to be incontinent, including during the night; (c) The resident is known to be incontinent, including during the night; (c) The resident is known to be incontinent, including during the night; (c) The resident is known to be incontinent, including the night; (c) The resident is checked during the night; (c) The resident is known to be incontinent to the resident are followed; and (f) Privacy is afforded to the resident when care is	DIMER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 1205 PONCE DE LEON AVE LAS VEGAS, NV 89123 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 waiver for one bedfast resident (Resident #5). Severity: 2 Scope: 1 449.27222 Residents having unmanageable condition of bowel or bladder incontinence; residents having manageable condition of bowel or bladder incontinence; residents having manageable condition of bowel or bladder incontinence shall ensure that: (a) If the resident can benefit from scheduled bloileting, he is assisted or reminded to go to the bathroom at regular intervals. (b) The resident is checked during those periods when he is known to be incontinent, including during the night; (c) The resident is checked and dry; (d) Retraining programs are designed by a medical professional with training and experience in the care of persons with bowel or bladder dysfunction; (e) The retraining programs established for a resident are followed; and (f) Privacy is afforded to the resident when care is

Division of	<u>of Public and Behaviora</u>	al Health				
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
	NVS4961AGZ		B. WING		06/27/	2013
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NAIVIE OF FI	ROVIDER OR SUFFLIER		NCE DE LEON A			
7TH HEAV	'EN		AS, NV 89123	W E		
04.0.45	CLIMMADY CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N.	0.450
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				DEFICIENCY)		
Y 755	Continued From page	: 5	Y 755			
	This Regulation is no	t met as evidenced by:				
		and interview on 6/25/13,				
		ovide assistance to the				
	bathroom and keep 1	of 5 residents clean and				
	dry. (Resident #5)					
	0	4				
	Severity: 2 Scope:	1				
Y 920	440 0740/4 0) Madica	stion Characa	Y 920			
SS=F	449.2748(1-2) Medica	ation Storage	1 920			
	NAC 449.2748 Medic	ation: Storage; duties upon				
	discharge, transfer an					
		ng, without limitation, any				
	over-the-counter med					
	_	st be stored in a locked area he caregivers employed by				
	_	e that any medication or				
		equipment that may be				
	•	ted by a resident or any				
	other unauthorized pe					
		al use only must be kept in a				
	locked area separate	from other medications. A				
	resident who is capab					
		without supervision may				
		n his room if the medication ntainer for which the facility				
	has been provided a l					
	nao boon provided a i	.cy.				
	2. Medication stored	in a refrigerator, including,				
	without limitation, any					
		ept in a locked box unless				
	-	ed or is located in a locked				
	room.					
	This Regulation is no	t met as evidenced by:				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Based on observation on 6/25/13, the facility

STATE FORM If continuation sheet 6 of 10

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		NVS4961AGZ	B. WING		06/27/2	2013
	ROVIDER OR SUPPLIER		RESS, CITY, STA			
7TH HEAV	EN	LAS VEGA	S, NV 89123			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
Y 920	Continued From page	e 6	Y 920			
	locked container (Med with key in lock, earw	cations were were kept in a dication cabinet unsecured ax remover in bathroom, m #4 and eye drops in				
Y 936 SS=D	449.2749(1)(e) Resident Tuberculosis	ent file-NRS 441A	Y 936			
		enance and contents of resident; confidentiality of				
	resident of a residenti least 5 years after he facility. The file must that is resistant to fire unauthorized use. The records, letters, assess information and any of the resident, including (e) Evidence of comp	ssments, medical ther information related to				
	Based on record reviet the facility failed to en complied with NAC 44	41A.380 regarding Resident #4 missing 2012 est).				

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STATE FORM 6899 V6VY11 If continuation sheet 7 of 10

Division of Public and Behavioral Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
	NVS4961AGZ		B. WING		00/07/0042
			L		06/27/2013
NAME OF P	ROVIDER OR SUPPLIER		ODRESS, CITY, STA NCE DE LEON A		
7TH HEAV	/EN		AS, NV 89123	v L	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
Y 991	Continued From page	e 7	Y 991		
Y 991 SS=F	449.2756(1)(b) Alzhe	eimer's Fac door alarm	Y 991		
	provides care to pers disease shall ensure (b) Operational alarm audible devices which	that: ns, buzzers, horns or other th are activated when a door ed on all doors that may be			
Y 994 SS=F	Based on observation failed to ensure 1 of 3 alarms that operated opened (Back patio e This is a repeat deficient annual State Licensur Severity: 2 Scope:	iency from the 12/5/11 re survey.	Y 994		
	provides care to pers disease shall ensure (e) Knives, matches, items that could cons	that: firearms, tools and other			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM 6899 V6VY11 If continuation sheet 8 of 10

Division of Public and Behavioral Health

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)			X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	UMBER: A. BUILDING:		COMPLI	ETED	
		NVS4961AGZ	B. WING		06/2	7/2013	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
7TH HEAV	'EN		E DE LEON A	VE			
			S, NV 89123				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
Y 994	Continued From page	e 8	Y 994				
Y 999 SS=F	This Regulation is not Based on observation failed to ensure danger accessible to 5 of 5 re in bedroom #4, scisso lighters on back pation	of met as evidenced by: n on 6/25/13, the facility erous items were not esidents (Unsecured pliers ors on kitchen counter and o and in room #5). ficiency from the 6/5/12 ey.	Y 999				
33-1	NAC 449.2756 Residence to persons with A Standards for safety; for employees. 1. The administrator of provides care to personal disease shall ensure (g) All toxic substance residents of the facility.	personnel required; training of a residential facility which ons with Alzheimer's that: es are not accessible to the y.					
	Based on observation failed to ensure toxic inaccessible to 5 of 5 paint on kitchen coun bedroom #5 and nail	residents (Unsecured spray					

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DA COI					
		NVS4961AGZ	B. WING		06	/27/2013		
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1205 PONCE DE LEON AVE							
7TH HEAV	/EN		SAS, NV 89123					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
Y 999	Continued From page	9	Y 999					
	annual State Licensu	re survey.						
	Severity: 2 Sco	pe: 3						
l								